A VIEW FROM THE MUNICIPAL HOSPITAL*

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How does one describe the experiences of cost containment in New York City in a Health and Hospitals Corporation facility supported in part by tax levy?

I have been affiliated with Bellevue Hospital Center since 1957, when I entered the Bellevue School of Nursing. The students were introduced to cost containment in our first ward experience, eight weeks into our freshman year. It was not called cost containment then but was termed shortage. The city hospitals had a chronic shortage of everything and everybody except patients.

How did this situation affect our morale and functioning? How did we envision ourselves as health care professionals and workers? Morale was high. Students and house staff were proud to be at Bellevue. All understood the tradition and philosophy of the institution and knew that they were part of the Bellevue family that believed in quality care for our patients. Our focus was on patient care and education. We functioned as a team as families used to do. We helped each other, and the now famous statement, "It's not my job" was unheard of. There were meaningful upgrading educational programs for nonprofessional staff and realistic opportunities for advancement for the professional staff. Absenteeism was rare both on the job and at social functions like Friday afternoon liver rounds.

It is now 20 years later. What has happened in those 20 years? Health care technology has exploded. We have progressed to the machine age. Unionization of many health care workers has evolved with strong and sometimes defiant postures. Individuals spend more and more of their time in turf-protection activities.

In the second half of the 1960s and the first half of the 1970s the money

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faucet was turned on by the government. Many of us felt we were nearing the promised land. The new Bellevue Hospital was at long last nearing completion. We were sure that with the move many of our problems would disappear. The new structure would attract a different socioeconomic group of patients, and housekeeping and maintenance would improve and be less costly. We would have new equipment. Recruitment and retention of quality staff would be greatly enhanced.

Then the unbelievable became reality. New York City was broke. Not only was a job freeze imposed, but employees at all levels were fired, laid off, or bumped. Many programs were destroyed or dismantled because of a lack of funds and staff. Other personnel chose to leave because of job insecurity and staff shortage. Particularly hard hit was the nursing staff. We dropped from the mountain top of hope to the valley of despair.

Why did we drop so low? Because during the past 10 or so years the atmosphere within Bellevue, as in society in general, lost a great deal of its united family atmosphere. The attitude had become, "What can I get?" rather than "What can I give?"

Morale plunged to a new low. Most staff were and are functioning at the base level of Maslow's hierarchy of needs. Low staffing patterns reinforce low morale and decrease quality patient care. The need for employees to work overtime, particularly in nursing, has become a new way of life to provide minimal patient care. This situation is certainly not cost containment and leads to budget overruns.

Nor are low salary scales for a traditionally mobile population cost effective in the long run. Staff nurses are an example. Because the Health and Hospitals Corporation's salary for staff nurses is one of the lowest in New York City, Bellevue attracts new graduates with no experience or foreign graduates, many of whom have language difficulties. This leads to longer orientation periods with increased costs. Many new graduates leave six or eights months later when they have gained some experience. This produces a high turnover rate with its attendant costs and decrease in quality patient care.

In the first week in April 1979 the Health and Hospitals Corporation announced a 100% attrition policy. This means that vacant jobs remain vacant and employees who leave are not replaced. In the *New York Times* of May 6, 1979, on a back page, was an article about the opening of the new Woodhull Hospital, part of the Health and Hospitals Corporation. I quote the second last paragraph in the article.

> Moreover, Woodhull was initially planned in the 1960's as a "dream hospital" that would offer poor Medicaid patients the kind of hospital accommodations usually reserved for the wealthy. However, private rooms require more hospital aides and nurses at a time when the city is being forced to lay them off to help cut its budget.

How appropriate are many of the budget cuts? Individuals at different levels of the health care team would respond to that question in different ways. As a nurse, I would have the most difficulty with cuts that affect direct delivery of patient care and the patient environment. There is an adage that says that a chain is only as strong as its weakest link. The finest structure with the best of professional staff will not long remain in that category without the appropriate levels of front-line troops such as nurses and nursing staff and support staff such as dietary, housekeeping, and transport aides.

Unionization and specific job descriptions for job titles have removed many of our old liberties to utilize employees. But beyond those restrictions is the concept and reality of appropriate utilization of our shrinking staffs. While a nurse, out of necessity, is serving a food tray, mopping up a spill, or transporting a patient, the nurse's skilled functions go unused. This surely is neither cost containment nor likely to improve patient care.

And then there is the paper deluge. No area of health care has been left untouched, from the director's office to the patients' charts to the forms and manuals for compliance with regulations. A recent survey in New York State discovered that 25% of the health care dollar in this state was spent in complying with regulations. In years past and probably gone forever, need for admission to a hospital and quality of patient care was assessed by observing and interviewing patients. Now the game, as we all know, has evolved into documentation and more documentation. In a fight for survival and to prove its worth to patient care, whether the individual is in the health care delivery system or in a regulatory or accreditation organization, each now bows before the shrine of the written word. The system has us so involved in reading and writing at all levels that there is scant time to talk and to listen to patients and their concerns.

Where do we go from here? Do we resign ourselves to the situation, throw up our hands in despair, spend inappropriate time and energy to protect our individual turfs, or fold up our tents and steal away into the night because of cost containment? If one is in the health care field, as I am, because one still believes in quality patient care and in caring for

patients as individual human beings, then one's answer, as mine is, must be "no."

In composing my thoughts for today, I recalled a quote from another time of crisis. Franklin Roosevelt, during his first inaugural address, stated, "The only thing we have to fear is fear itself." In this time of cost containment and monetary crisis I recommend reflection, reevaluation, and establishment of a priority of needs. Retrenchment and reorganization have to be carefully scrutinized and instituted according to patient care needs. We must find new ways to motivate ourselves and our staffs. We must rekindle the morale of years gone by in order to continue to provide quality patient care.